IP 01-1437-C B/S Isaac v. Seabury & Smith, Inc
Judge Sarah Evans Barker Signed on 7/5/02

INTENDED FOR PUBLICATION AND PRINT

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

ISAAC, RONALD G PERSONAL REPRESENTATIVE OF THE ESTATE OF JUDY AMBURGEY, Plaintiff, vs. SEABURY & SMITH INC, MARSH ADVANTAGE AMERICA, FIRST ALLMERICA FINANCIAL LIFE INSURANCE COMPANY, Defendants.	)	CAUSE NO. IP01-1437-C-B/S

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

RONALD S. ISAAC, Personal Representative of JUDY AMBURGEY, Plaintiff,	)	
vs.	)	IP01-C-1437 B/S
SEABURY & SMITH, INC., MARSH ADVANTAGE AMERICA, and FIRST ALLMERICA FINANCIAL LIFE INSURANCE COMPANY, Defendant.	)	

ENTRY ON PENDING MOTIONS

I. *Introduction.*

This case is before the court on two related motions: plaintiff's motion to remand the case to Marion County Superior Court on the ground that it states a cause of action under Indiana tort law, and, therefore, its removal to this court was improper; and defendant's motion for summary judgment on the grounds that the cause of action is completely preempted by ERISA and that the plaintiff is not entitled to relief under the federal statute. Although defendants have moved for summary judgment, the material facts are essentially uncontested so that the key issues raise pure matters of law.

This is a case of first impression in our circuit. It ultimately turns on the proper interpretation of *Pegram v. Herdrich*, 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000). The parties have crystallized the issues in well-prepared briefs. Based on our reading of *Pegram* and the parties' submissions, we conclude that the claims alleged in the complaint arise in an area that is *not* occupied

by ERISA so that the case was improvidently removed. In other words, plaintiff's complaint is not subject to complete preemption by ERISA. Accordingly, we GRANT plaintiff's motion to remand and DENY defendants' motion for summary judgment.

I. *Discussion.*

A. *Factual Background.*

The essential facts of this case are undisputed. They are outlined in the parties' statements of fact, submitted pursuant to Local Rule 56.1, which we summarize as follows.

Judy Amburgey was employed by Spartech Corporation. Spartech maintained a health benefit plan for its employees. The plan was funded by a health insurance policy issued to Spartech by defendant First Allmerica Life Insurance Co. Seabury & Smith served as the third-party administrator of the plan.[1]

The plan is a "fee-for-service" plan and not an HMO arrangement. In other words, no entity provided both claims administration and patient treatment. Instead, beneficiaries of the plan such as Ms. Ambrugey were free to choose their health care providers and the policy then paid for covered procedures as expenses were incurred.

Ms. Ambrugey contracted leukemia. She was treated at the University of Texas MD Anderson Center in Houston. On August 10, 1999, Ms. Ambrugey's oncologist, Dr. Thomas Martin, wrote a letter marked "Urgent Review Requested," which Seabury & Smith answered on August 25. Dr.

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[1]Defendants assert, without challenge, that Marsh Advantage America is a division of Seabury & Smith and has no separate identity. Answer ¶ 3.

Martin's letter described his diagnosis of Ms. Ambrugey's chronic myelogenous leukemia and stated that her case is unlikely to be cured by chemotherapy or radiation; instead, he wrote, "[t]he only documented therapy capable of curing this disease is bone marrow transplantation from a histocompatible donor." Pl. Ex. 1. Because of Ms. Ambrugey's "unstable medical condition," Dr. Martin asked the plan administrator for authorization of insurance coverage in order to proceed quickly with the transplantation process, beginning with the search for a compatible donor. *Id.*

On August 25, 1999, Andrea M. Salvati, a Vice President with Seabury & Smith, wrote back to Dr. Martin denying coverage of the treatment. She stated that the transplant "cannot be considered a covered expense pursuant to the terms and conditions of the employee welfare benefit plan"; based on the review of the supporting documentation by "a board certified Oncologist," she wrote, the procedure was not covered because it was not "medically necessary." Pl. Ex. 2.

This initial denial was modified on September 23, 1999, when Dr. Sheila Donnelly, writing for Seabury & Smith, gave "conditional approval" for the transplant. Pl. Ex. 3. Ms. Ambrugey died on October 7, 1999, before any transplant was undertaken.

III. *Discussion.*

The motions before us raise two related questions: whether defendants' removal of this case from Marion County Superior Court to this court was proper; and whether ERISA completely preempts plaintiff's state law claim. To answer either of these questions is to answer both. If the case arises under ERISA (as defendants claim), then it was properly removed to federal court and it is subject to summary adjudication as a matter of law. If the case does not arise under federal law (as

plaintiff argues), then there was no basis for removal and our authority is limited to remanding it. These issues are best addressed in terms of defendants' argument for "complete preemption," which we will turn to shortly.

A case may be removed from a state to a federal court when the case could have been brought in a federal court originally.[2] If the federal court would have had original jurisdiction by virtue of a federal question raised by the complaint – as defendants argue here – then removal would be proper under 28 U.S.C. § 1441(b).[3] We note at the outset that plaintiff's "Complaint in Tort," on its face, alleges nothing but state law causes of action. It accuses defendants of breaching their duty to exercise fairness, reasonableness, and good faith in handling her insurance claim, and of negligence in making decisions affecting her medical treatment. Complaint ¶¶ 7-12. Nothing on the face of the complaint gives rise to an inference that it states a federal question.

But, argue defendants, plaintiff's lawsuit is really an ERISA breach-of-fiduciary-duty claim masquerading as a state tort cause of action. In other words, defendants argue, had plaintiff not artfully

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[2]28 U.S.C. § 1441(a) provides for removal in general: "Except as otherwise expressly provided by Act of Congress, any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending. For purposes of removal under this chapter, the citizenship of defendants sued under fictitious names shall be disregarded."

[3]Section 1441(b) provides: "Any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties. Any other such action shall be removable only if none of the parties in interest properly joined and served as defendants is a citizen of the State in which such action is brought." Removal on the basis of federal question jurisdiction is the only issue here, since defendant does not argue for diversity jurisdiction, which is governed by section 1441(c).

pleaded its cause of action to avoid ERISA, the federal court would have had original jurisdiction over it. *Franchise Tax Board of California v. Construction Laborers Vacation Trust*, 463 U.S. 1, 22, 103 S.Ct. 2841, 77 L.Ed.2d 420 (1983). Defendants argue, in sum, that this matter is completely preempted by ERISA; it follows that its removal to federal court was proper and it may be summarily dismissed.

Generally, when a defendant argues for "preemption" it means one of two things: that federal law *governs* the cause of action; or that federal law not only *governs* the cause of action, but *occupies the field* in which the complaint allegations arise. The former meaning is usually referred to as "conflict preemption" and gives rise to a *defense*; the latter meaning is usually referred to as "complete preemption" and gives rise to original federal jurisdiction and the possibility of removal to federal court. The Supreme Court has noted that:

> Federal pre-emption is ordinarily a federal defense to the plaintiff's suit. As a defense, it does not appear on the face of a well-pleaded complaint, and, therefore, does not authorize removal to federal court. *Gully v. First National Bank, supra*. One corollary of the well-pleaded complaint rule developed in the case law, however, is that Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character. For 20 years, this Court has singled out claims pre-empted by § 301 of the LMRA for such special treatment. *Avco Corp. v. Machinists*, 390 U.S. 557, 88 S.Ct. 1235, 20 L.Ed.2d 126 (1968).

Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63-64, 107 S.Ct. 1542, 1546, 95 L.E.2d 55 (1987). *See Bartholet v. Reishauer A.G. (Zurich)*, 953 F.2d 1073 (7th Cir.1992).

When a defendant uses preemption as a defense, the case is not removable to federal court, because the *defense*, and not the *complaint*, raises the federal issue; where that is true, a federal court would not have had original jurisdiction had it been filed there. In such a case, the defendant is free to

argue in *state* court that federal law preempts the cause of action because federal law *governs* it. *See, Lehmann v. Brown,* 230 F.3d 916, 919-920 (7th Cir. 2000); *Blackburn v. Sundstrand Corp.*, 115 F.3d 493, 495 (7th Cir.), *cert. denied*, 522 U.S. 997, 118 S.Ct. 562, 139 L.Ed.2d 403 (1997) (A defendant's federal defense to a claim arising under state law "does not create federal jurisdiction and therefore does not authorize removal.") . This is often called "conflict preemption." Here, it is created by 29 U.S.C. § 1144(a). *Speciale v. Seybold*, 147 F.3d 612, (7th Cir. 1998).

By contrast, where, as here, a defendant argues that a federal law– ERISA – *completely* preempts a state cause of action it means that the case is federal by its very nature, regardless of how the complaint is styled. As Judge Easterbrook explained in *Lehmann,* 230 F.3d at 919-920:

> Unfortunately "complete preemption" is a misnomer, having nothing to do with preemption and everything to do with federal occupation of a field. The name misleads because, when federal law occupies the field (as in labor law), every claim arises under federal law. *See In re Amoco Petroleum Additives Co.*, 964 F.2d 706, 709-10 (7th Cir.1992). Any attempt to present a state-law theory then is artful pleading to get around the federal ingredient of the claim; courts look at substance, see the importance of federal law to recovery, and permit removal. *Franchise Tax Board of California v. Construction Laborers Vacation Trust,* 463 U.S. 1, 22, 103 S.Ct. 2841, 77 L.Ed.2d 420 (1983). ERISA occupies much of the field of pension and fringe benefits; the size and distribution of these benefits depends on federal law, so *Metropolitan Life* holds that a claim to benefits necessarily "arises under" federal law no matter how it is pleaded. State law is "completely preempted" in the sense that it has been replaced by federal law – but this happens because federal law takes over all similar claims, not because there is a preemption defense. *See, e.g., Anderson v. Humana, Inc*., 24 F.3d 889 (7th Cir.1994) (discussing the provision of information to beneficiaries, another respect in which federal law has completely taken over).

There are two areas of federal law that completely – or, more precisely, *almost* completely – occupy their respective fields. One is labor relations, which is dominated by the National Labor Relations Act and the Labor Management relations Act; the second is ERISA. *See, Rice v. Panchal,*

65 F.3d 637, 643 (7th Cir. 1995).[4] In *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959, 967 (7th Cir. 2000), *affirmed, Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151 (June 20, 2002), the Seventh Circuit outlined the following criteria to consider in determining whether a claim is completely preempted by ERISA – that is, whether a state law claim should be "recharacterized" as an ERISA claim under § 502(a):

> (1) "whether the plaintiff is eligible to bring a claim under that section"; (2) "whether the plaintiff's cause of action falls within the scope of an ERISA provision that the plaintiff can enforce via § 502(a)"; and (3) "whether the plaintiff's state law claim cannot be resolved without an interpretation of the contract governed by federal law." When all three factors are present, the state law claim is properly recharacterized as an ERISA claim under § 502(a). [Quoting *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1487 (7th Cir.1996).]

The question in the instant case is whether plaintiff's cause of action satisfies these criteria so that its claim should be recharacterized as an ERISA claim, removed to federal court, and summarily adjudicated. Based on our understanding of *Pegram*, we conclude that plaintiff's cause of action does not "fall within the scope" of ERISA and thus fails to satisfy the second criterion.

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[4]Labor relations provides an instructive analogy. In that area of law, in order to determine whether a state tort law cause of action is completely preempted by federal statute, the court asks "whether evaluation of the tort claim is inextricably intertwined with consideration of the terms of the labor contract," *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 213, 105 S.Ct. 1904, 85 L.Ed.2d 206 (1985), or (much the same thing) whether the tort analysis is "substantially dependent" upon analysis of the labor agreement. Id at 220. *See Lingle v. Norge Div. of Magic Chef, Inc.*, 486 U.S. 399, 405-06, 108 S.Ct. 1877, 100 L.Ed.2d 410 (1988). If the answer to either question is "yes," the state cause of action is completely preempted. It is removable to federal court and subject to disposition pursuant to the federal substantive law. By contrast, "the bare fact that a collective-bargaining agreement will be consulted in the course of state-law litigation plainly does not require the claim to be extinguished." *Livadas v. Bradshaw*, 512 U.S. 107, 124, 114 S.Ct. 2068, 129 L.Ed.2d 93 (1994). In that event, the state law claim is not preempted.

Pegram was an ERISA breach-of-fiduciary-duty case that directly involved neither preemption nor removal.[5] By the time the district court ruled on defendant's motion to dismiss, the case involved the straightforward question of whether an HMO breached its fiduciary duty to otherwise eligible beneficiaries by offering its employee physicians a financial incentive to deny benefits to the beneficiaries. The plaintiff argued that, since the HMO awarded bonuses to its physicians based on the value of the benefits they *denied* to beneficiaries, it created a financial incentive for the physicians to deny coverage whenever possible, thus breaching its duty to administer the plan for the benefit of the beneficiaries. The Supreme Court determined that offering such an incentive was not, as a matter of law, a fiduciary duty decision so that the complaint did not state a viable cause of action under ERISA.

In arriving at its decision, the Supreme Court focused on three kinds of decisions that HMOs make: eligibility or coverage decisions; treatment decisions; and mixed decisions of treatment and eligibility. Eligibility decisions are the most straightforward (and perhaps the most common): does the plan cover pregnancy? is this beneficiary eligible, under the plan, for such-and-such procedure? Eligibility and coverage questions are resolved by looking at the welfare benefit plan. Such decisions are the very stuff of ERISA, which completely preempts all coverage and eligibility decisions. *E.g.*,

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[5]*Pegram* started out as a state law cause of action, filed in Illinois state court, alleging medical malpractice and fraud. The defendant removed the case to federal court. Removal never became an issue, however, because, after removal, the federal district court permitted the plaintiff to amend her state law cause of action. She amended it so that it clearly and forthrightly stated a breach of fiduciary duty claim under ERISA, 29 U.S.C. § 502. Accordingly, by the time the court addressed the case on the merits, it no longer mattered where the case had been initiated or whether ERISA preempted her original claim. The amended complaint raised a federal question and the district court had original jurisdiction over it.

Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482, 1487 (7th Cir.1996).

Thus, for example, where a plaintiff alleges in a state breach of contract action that an employee welfare benefit plan unlawfully breached its agreement to provide benefits, the case is preempted by ERISA. *Shannon v. Shannon*, 965 F.2d 542, 546 (7th Cir. 1992), *cert. denied*, 506 U.S. 1028 , 113 S.Ct. 677, 121 L.Ed.2d 599; *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 278 (3d Cir. 2000). Similarly, where a plaintiff alleges in a state tort action that a plan representative negligently misrepresented coverage under the plan, such a claim is preempted by ERISA. *Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126, (7th Cir. 1992). Both the contract and tort cases involve the plan's coverage or the beneficiary's eligibility (which are, often enough, opposite sides of the same coin) and those kinds of decisions are preempted.

At the opposite end of the spectrum from coverage or eligibility decisions are pure "treatment" decisions (which are rare in ERISA case law). The Third Circuit held, for example, that a plan's provision that all newborns were to be released from the hospital within twenty-four hours after birth was a "quality of care" (that is, a "treatment") decision.[6] *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 153 (3d Cir.1999). It also opined that "a claim alleging that a physician knowingly delayed in performing urgent surgery on a patient whose appendix was about to rupture would relate to the quality of care, and not be subject to removal on the basis of complete preemption." *Pryzbowski*, 245 F.3d at 273. The reason is that quality of care decisions are, like medical malpractice claims, among the

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[6] The Third Circuit's distinction between "quality of care" and "administration of benefits" is roughly analogous to the Supreme Court's distinction between "treatment"decisions on the one hand and "coverage" or "eligibility" decisions on the other. *Pryzbowski*, 245 F.3d at 272; *Trotter v. Perdue Farms, Inc.*, 168 F.Supp.2d 277, 286 (D.Del., Oct 15, 2001)

fields "traditionally occupied by state regulation." *Dukes,* 57 F.3d at 357; *Pryzbowski,* 245 F.3d at 279.

For present purposes, the crucial (and most controversial) category in *Pegram* is the "mixed" eligibility and treatment decision, which includes an enormous number of decisions made by HMOs and other employee welfare benefit plans every day. Frequently, as here, these decisions involve the question of whether a particular procedure is "medically necessary." Some decision maker, often a physician, makes a determination as to whether the requested procedure is "medically necessary" and, in doing so, determines whether the patient is "eligible" for such "treatment." In other words, the decision inevitably involves *both* a decision as to eligibility/coverage and a decision as to treatment and the two parts are inextricably intertwined. About such decisions the Supreme Court wrote:

> In practical terms, these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment, and in the case before us, Dr. Pegram's decision was one of that sort. She decided (wrongly, as it turned out) that Herdrich's condition did not warrant immediate action; the consequence of that medical determination was that Carle [the HMO] would not cover immediate care, whereas it would have done so if Dr. Pegram had made the proper diagnosis and judgment to treat. *The eligibility decision and the treatment decision were inextricably mixed, as they are in countless medical administrative decisions every day*.

Pegram, 530 U.S. at 229, 120 S.Ct. at 2154 (emphasis added). Such mixed decisions include:

> physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than Carle's; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition.

530 U.S. at 229-230, 120 S.Ct. at 2155. Significantly for the instant case, the court characterized many such mixed decisions as "medical necessity determinations," Id., and as "utilization review," which it described as the procedure by which "specific treatment decisions are reviewed by a decisionmaker

other than the treating physician." 530 U.S. at 219, 120 U.S. at 2149.[7]

In view of the Court's outline, we think it evident that the decisions at issue in this case come under the heading of mixed decisions of eligibility and treatment. Pursuant to determinations made by physicians – "a board certified oncologist" in the first instance, and Dr. Sheila Donnelly in the second – Seabury & Smith made two decisions: one denied Ms. Ambrugey coverage because the requested transplant procedure was not "medically necessary"; the second countermanded the first – in effect, finding it to be within the bounds of "medical necessity" – and gave "conditional approval" for the operation. Both decisions manifestly involved a question of coverage/eligibility – whether the costs of the bone marrow transplant operation would be covered or (essentially the same thing) whether Ms. Ambrugey was eligible for a transplant – and a treatment decision – whether a transplant was medically necessary.

It is the clear holding of *Pegram* that mixed decisions concerning eligibility and treatment are not fiduciary decisions for purposes of ERISA: "We hold that mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA. 530 U.S. at 237, 120 U.S. at 2158. In the narrow sense, this means that a lawsuit alleging breach of fiduciary duty which involves a mixed decision is subject to dismissal pursuant to Rule 12(b)(6). It follows that the plaintiff's cause of action does not

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[7]The *Pegram* Court cited Andresen, Is Utilization Review the Practice of Medicine?, Implications for Managed Care Administrators, 19 J. Legal Med. 431, 441 (Sept.1998), which, while not answering the question directly, notes that: "[H]ealth care providers, as a group, claim that prospective utilization review decisions equate to a medical decision. Some oppose the practice, arguing that UR administrators are exercising medical judgment without sufficient knowledge or ability to determine medical necessity. Others cite its potential to interfere with the physician- patient relationship as the main concern."

satisfy *Rush*'s second criterion: that it "fall[] within the scope of an ERISA provision that the plaintiff can enforce via § 502(a)." *Rush*, 230 F3d at 967; *See, Rush*, 122 S.Ct. at 2177, n. 7 (Thomas, J. dissenting).

Defendants present three arguments in support of complete preemption. First, plaintiff's cause of action is completely preempted because it "relates to" a welfare benefit plan. Second, plaintiff's complaint makes no sense under Indiana law. And third, the defendants here are not an HMO – they are, instead, a third-party administrator of the plan and, accordingly, have no role in patient "treatment."

Defendants' first argument glosses over the distinction between complete preemption – which is the only issue here – and conflict preemption pursuant to 29 U.S.C. § 1144(a). Because we conclude that plaintiff's cause of action is not completely preempted by ERISA and that we must, accordingly, remand this case to Marion Superior Court, we have no jurisdiction to hazard an opinion as to whether the cause of action is subject to an ERISA preemption defense in state court or plaintiff's corollary argument that it is "saved" by ERISA's insurance law exception. *See Rush Prudential*, 122 S.Ct. 2151. That being noted, we conclude the complete preemption part of our discussion by noting that both *Pegram* and the Seventh Circuit's decision in *Lehmann* lead to the proposition that, while a state court action involving a mixed decision may be subject to *conflict* preemption, it is not removable to federal court because ERISA simply doesn't occupy the field in which mixed decisions arise. In *Lehmann,* 230 F.3d at 920, which relies on *Pegram*, the Seventh Circuit observed:

> When the complaint alleges that a welfare-benefit plan has committed a tort – for example, when a physician employed by a HMO that has been offered as a benefit to employees commits medical malpractice – *the claim must arise under state law, because ERISA does*

> *not attempt to specify standards of medical care.* See *Pegram v. Herdrich*, 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000). Claims outside the scope of ERISA arise independently of federal law, and the possibility that § 514(a) preempts one or another state-law theory is just *a federal defense*. [Emphasis added.]

In sum:

> The district judge appears to have believed that any claim preempted by § 514(a) of ERISA, because "related to" a pension or welfare plan, may be removed to federal court. This, however, is not so. Following established precedent, we have distinguished between federal defenses, such as preemption, which must be presented to state court, and claims based on federal law, which are removable.

Id.

Defendants' second argument is related to the first and fares no better. They argue that plaintiff's complaint allegations do not state a cognizable medical malpractice case under Indiana law (indeed, that it doesn't even purport to do so); nor do they state a cognizable insurance action under Indiana law. From these facts they ask us to infer that plaintiff's cause of action must really be one for breach of fiduciary duty, but that such an action is preempted by ERISA. Even assuming that plaintiff's complaint allegations do not state a viable cause of action under Indiana law, we may not infer from that assumption that the claim gives rise to federal jurisdiction. The cause of action may, indeed, be invalid under Indiana law. Even so, once we decide that ERISA does not completely preempt the cause of action, our only mandate is to remand the case and make way for the state court to make that determination. *Lehmann*, 230 F.3d at 920. We hazard no opinion as to the merits of plaintiff's complaint allegations or as to the question of whether ERISA preempts the state cause of action because state law *conflicts* with ERISA. These are matters for the state court to decide. *See*, *Vorhees v. Naper Aero Club, Inc.*, 272 F.3d 398 (7th Cir. 2001); *Lehmann*, 230 F.3d at 919-920.

Defendants' third argument – that this case involves not an HMO, but a third-party administrator – makes this case unique in our circuit. It has found support in one circuit court and several district court opinions. *Corporate Health Ins. v. Texas Department of Insurance*, 220 F.3d 641 (5th Cir.2000); *Rubin-Schneiderman v. Merit Behavioral Care Corp.*, 163 F.Supp.2d 227 (S.D.N.Y. 2001); *Cicio v. Vytra Healthcare*, --- F.Supp.2d ----, 2001 WL 1860036 (E.D.N.Y., Sep 28, 2001); and *Marks v. West Virginia Dept. of Health & Human Resources*, 181 F.Supp.2d 639 (S.D.W.Va., 2002) (relying on Rubin-Schneiderman).[8] *Rubin-Schneiderman* and *Cicio* conclude that *Pegram* is essentially irrelevant to the question of complete preemption because *Pegram* involved an *HMO*, whereas these cases involve a *third-party administrator* and not an HMO. The nub of the district court cases is that, while an HMO provides both claims administration and treatment, a third-party administrator does not provide treatment. Instead, even though it appears to be making mixed decisions of eligibility and treatment, it is really serving in only an administrative capacity, because it provides no actual medical care. It is thus completely preempted because in the area of benefits administration ERISA occupies the field. *Rubin-Schneiderman*, 163 F.Supp.2d at 231; *Cicio*, 2001 WL 1860036 at *11.[9]

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[8]Defendants also cite *Shusteric v. United Healthcare Insurance Co. of Illinois*, 2000 WL 1263581 (N.D.Ill. 2000), which holds that the plaintiff's tort case (not unlike the one here) was properly removed and completely preempted by ERISA. Judge Conlon questioned how the plaintiff could either distinguish her case from *Jass* or show why *Jass* has become "bad law." We think an answer is supplied in part by our conclusion that, because of *Pegram*, plaintiff's cause of action does not satisfy the second *Jass* criterion for complete preemption under section 502(a).

[9]The *Corporate Health Insurance* case is more complicated. It involves the question of whether ERISA preempts a Texas state statute which creates an Independent Review Organization (IRO) regime under the state's laws regulating insurance. In language supporting the New York district court cases, the Fifth Circuit noted that not every mixed decision of eligibility and treatment survives

We respectfully disagree for the following reasons. First, the *Pegram* court did not focus on the *treatment* of covered beneficiaries or on *who* provided the treatment. It focused on *decisions*: eligibility *decisions*, treatment *decisions*, and mixed *decisions* of treatment and eligibility. Regardless of who makes these decisions, they are all decisions which affect beneficiaries. We find no principled way to distinguish between a mixed decision of eligibility and treatment rendered by a physician employed by an HMO (as in *Pegram*) and a mixed decision of eligibility and treatment rendered by a physician engaged by a third-party administrator to make such decisions (as in the instant case). Although the *Rubin-Schneiderman, Marks,* and *Cicio* courts appear to have found this distinction determinative, we fail to see how, under the *Pegram* regime, the nature of the enterprise – HMO or third-party administrator – is a pertinent factor in determining whether ERISA completely occupies the field.[10]

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preemption after *Pegram*. 220 F.3d at 643. Instead, it interpreted *Pegram's* exception to fiduciary duty analysis to apply largely, if not exclusively, to medical malpractice lawsuits and therefore to the direct negligence of *a health care provider* – that is, an actual provider of medical services. Since the IRO does not provide medical services, but is instead limited to the review of "adverse determinations" – including "determinations by managed care entities as to coverage, not just negligent decisions by a physician" – then it "create[d] an alternative mechanism through which plan members may seek benefits due them under the terms of the plan. . ." It thus duplicated the relief offered under § 1132(a)(1)(B) of ERISA. Accordingly, the Texas statute was preempted.

[10]Consider the following statement from *Cicio*:

> In *Pegram,* the defendant HMO was a direct medical services provider. The treating physician and HMO were one in the same. *See id.* at 2147. Here, Vytra acted solely in the role of a plan administrator and was not the medical services provider. Vytra's role was limited to determining whether the proposed treatment qualified as an experimental procedure under the terms of the plan. Although Vytra's benefits determination may have involved some medical judgment, this may be said of countless medical administrative made decisions every day. *See id.* at 2153. There is no evidence that Congress intended that these quasi-medical/administrative decisions made by a plan administrator survive ERISA preemption. Vytra's coverage determination cannot be separated or construed apart from the ERISA plan. Vytra functioned solely as a plan administrator and bore no responsibility as a provider of medical services in this action. For this

Additionally, while two courts point to cases with similar facts that led to removal and dismissal, the cases they cite were decided before *Pegram*. *E.g. Vytra*, 2001 WL 1860036 at *4; *Rubin-Schneiderman*, 163 F.Supp.2d at 230.

Second, the Seventh Circuit in *Lehmann* – a post-*Pegram* decision – did not limit its holding to "HMOs" or to "medical malpractice" when it concluded that a complaint alleging that "*a welfare-benefit plan*" has committed "a tort" must arise under state law, because ERISA does not attempt to specify "*standards of medical care*." An HMO is merely one form of "welfare benefit plan"; others include the kind of plan at issue here. Similarly, medical malpractice is merely one example of a "tort" that is not preempted by ERISA. Presumably, others may be asserted which challenge decisions affecting "standards of medical care."

Once again, we offer no opinion as to the viability of plaintiff's state causes of action. Nor do we offer any opinion as to the soundness of defendant's preemption defense in state court. We merely find that ERISA does not occupy the territory in which plaintiff's cause of action arises so that its removal to this court was improvident.

IV. *Conclusion.*

Because we conclude that ERISA does not completely preempt plaintiff's state law causes of action, we GRANT plaintiff's motion to remand to Marion Superior Court and we DENY defendants'

> reason, the challenge here does not target the quality of care but rather attacks the benefits decision that was made. This determination is preempted by ERISA.

2001 WL 1860036 at *11. We see no clear distinction between a "quasi-medical/administrative decision" and a "mixed decision of eligibility and treatment."

motion for summary judgment.

It is so ORDERED this _____ day of July 2002.

SARAH EVANS BARKER, JUDGE
United States District Court
Southern District of Indiana

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